30 JUN 2015 Waterfront Meeting

	Speaker	Topic	Time
Lecture Pretests			10
MRD-SD	LT Hightower	Opening Remarks	10
NMCSD ED	Dr. Carstairs	Poisoned Patient	45
FST	Dr. Clapp	Allergies and Anaphylaxis	45
University of SD	CDR Buechel	HPV Study	5
Fleet Dental	CAPT Roncone	Dental Updates	5
MRD-SD	LT Hightower	Updates	5
Lecture Posttests			10
		Total	135

Pre Test

Please start on the quizzes as soon as you find a seat!

Put your name on the quiz and **pass to the end of the row (left) when you are done.**

January Chest Pain- Dr. Oakley Triage- LT Feroli February Shock- Dr. Mecklenburg Pulmonary Emergencies- Dr. Powers March Acute Pain- Dr. Voogd Surgical Abdomen- Dr. Ignacio	April Airway Management- Dr. Hauff May Dental- LT Meadows (IDC's) Ultrasound- Dr. Hurst (MO's)

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Management of the Poisoned Patient

Shaun D. Carstairs, M.D. FACMT FACEP
CDR MC USN
30 June 2015

Introduction

- Poisoning emergencies common in the ED
  - 2.5 million toxic exposures reported in 2009
  - 1544 deaths
- Clinical effects dependent upon many variables
  - Dose
  - Length of exposure time
  - Pre-existing health of patient

Clin Toxicol (Phila) 2010; 48:979-1178

Objective

- To provide basic concepts for evaluation and appropriate management of the poisoned patient

Topics

- Resuscitation/initial management
- Diagnostic approach
  - History/physical exam
  - Toxidromes
  - Electrocardiogram
  - Laboratory analysis
- Treatment approach
  - Decontamination
  - Antidotes
  - Enhancement of clearance

Resuscitation and Initial Management

Initial Management

- Thorough assessment
- Appropriate stabilization
- Supportive care

- Consider a broad differential diagnosis

MISTAKE #1

- Assuming a patient’s presenting symptoms are due to a toxicologic cause without excluding potentially serious conditions

Case #1

- 25 year old male with history of drug abuse found “altered” at home by parents
- VS: T 100.3, R 20, P 130, BP 100/60
- Confused, dry skin/mucous membranes
- Looks antimuscarinic
- …. or is he?
- Lumbar puncture ✉ 590 WBC

Case #2

- 21 year old Marine, found down
- Strong smell of EtOH
- Placed in the front hallway to “sleep it off”
- … only he doesn’t wake up in the morning
- Head CT shows intracranial hemorrhage

Initial Management

- Same as the non-poisoned patient
  - ABC's
  - IV, O_2, cardiac monitoring
- Depressed mental status
  - Check blood glucose
  - Consider naloxone and/or thiamine as indicated

Circulatory Status

- Large-bore IV’s
- Strongly consider central venous access, esp. if hypotensive
- In hypotensive patients, mechanism of toxicity can guide vasopressor choice
  - Direct vasopressors preferred
  - Dopamine not an ideal agent in poisoned patients

History & Physical Examination

History

- Name and amount of agent(s)
- Time of ingestion/exposure
- Route of exposure
- Co-ingestants
- Reason for exposure (i.e., suicidal, accidental)
- Search exposure environment for pill bottles, drug paraphernalia, suicide note, chemical containers, etc.

Vital Signs

- Blood pressure
- Heart rate
- Respiratory rate/depth
  - Increased: salicylates, toxic alcohols
  - Decreased: opioids
- Temperature
  - High: salicylates, sympathomimetics, antimuscarinics, serotonin toxicity, NMS
  - Low: opioids, sedative-hypnotics

Physical Examination

- Pupillary size/reactivity
  - Large: sympathomimetics, antimuscarinics
  - Small: opioids, cholinergics
- Nystagmus
  - Ethanol, phenytoin, PCP, DXM, ketamine
- Dysconjugate gaze

Physical Examination

Physical Examination

- Mental status
  - Agitation
  - Confusion
  - Obtundation
- Skin
  - Warm: sympathomimetics, antimuscarinics
  - Moist: sympathomimetics, cholinergics
  - Dry: antimuscarinics

Physical Examination

- Lungs – bronchorrhea, wheezing
- Bowel sounds
- Neurologic examination
- Urination/defecation
- Odors

Toxidromes

- **Toxi**cologic syn**dromes**
- Constellation of signs and symptoms suggestive of a specific receptor effect
- Helpful in establishing diagnosis when exposure is unclear
- Many have overlapping features
- Warning: not all patients will have a “classic” toxidrome

Case

- 21 year old male
- Found unresponsive with needle in arm
- VS: T 97.0, R 4, P 60, BP 90/60
- Pupils 1mm bilaterally
- Skin cool/clammy

Opioid

- Sedation
- Miosis
- Decreased respirations
- Decreased bowel sounds

Case

- 18 year old male presents combative, mumbling, and incoherent
- VS: T 102.0, R 20, P 122, BP 138/78
- Pupils 6mm bilaterally
- Skin red, warm, and dry

Antimuscarinic

- Agitation/sedation
- Hallucinations
- Mydriasis
- Dry skin/MM’s
- Decreased bowel sounds
- Urinary retention

Antimuscarinic

- Agitation/sedation
- Hallucinations
- Mydriasis
- Dry skin/MM’s
- Decreased bowel sounds
- Urinary retention

Case

- Date: 3/20/1995
- 35 year old female presents with tonic-clonic seizures
- VS: T 99.0, R 5, P 45, BP 90/40
- Pupils 2 mm bilaterally
- HEENT: Secretions/vomit in mouth & nose
- Lungs: Rales & wheezing
- Skin: diaphoretic

Cholinergic

- Diarrhea
- Urination
- Miosis
- Bradycardia
- Emesis
- Lacrimation
- Salivation

Case

- 23 year old male brought to ED by ambulance
- Found unresponsive outside rave party
- VS: T 97.0, R 8, P 55, BP 107/55
- Pupils 5 mm bilaterally
- GCS 5

Sedative-Hypnotic

- Sedation
- Normal pupils
- Decreased respirations

Case

- 45 year old male found screaming outside his hotel
- Agitated
- VS: T 103.5, R 20, P 140, BP 190/110
- Pupils 6 mm bilaterally
- Skin: diaphoretic

Sympathomimetic

© Warner Bros. Pictures

- Agitation
- Mydriasis
- Tachycardia
- Hypertension
- Hyperthermia
- Diaphoresis

Electrocardiogram

Electrocardiogram

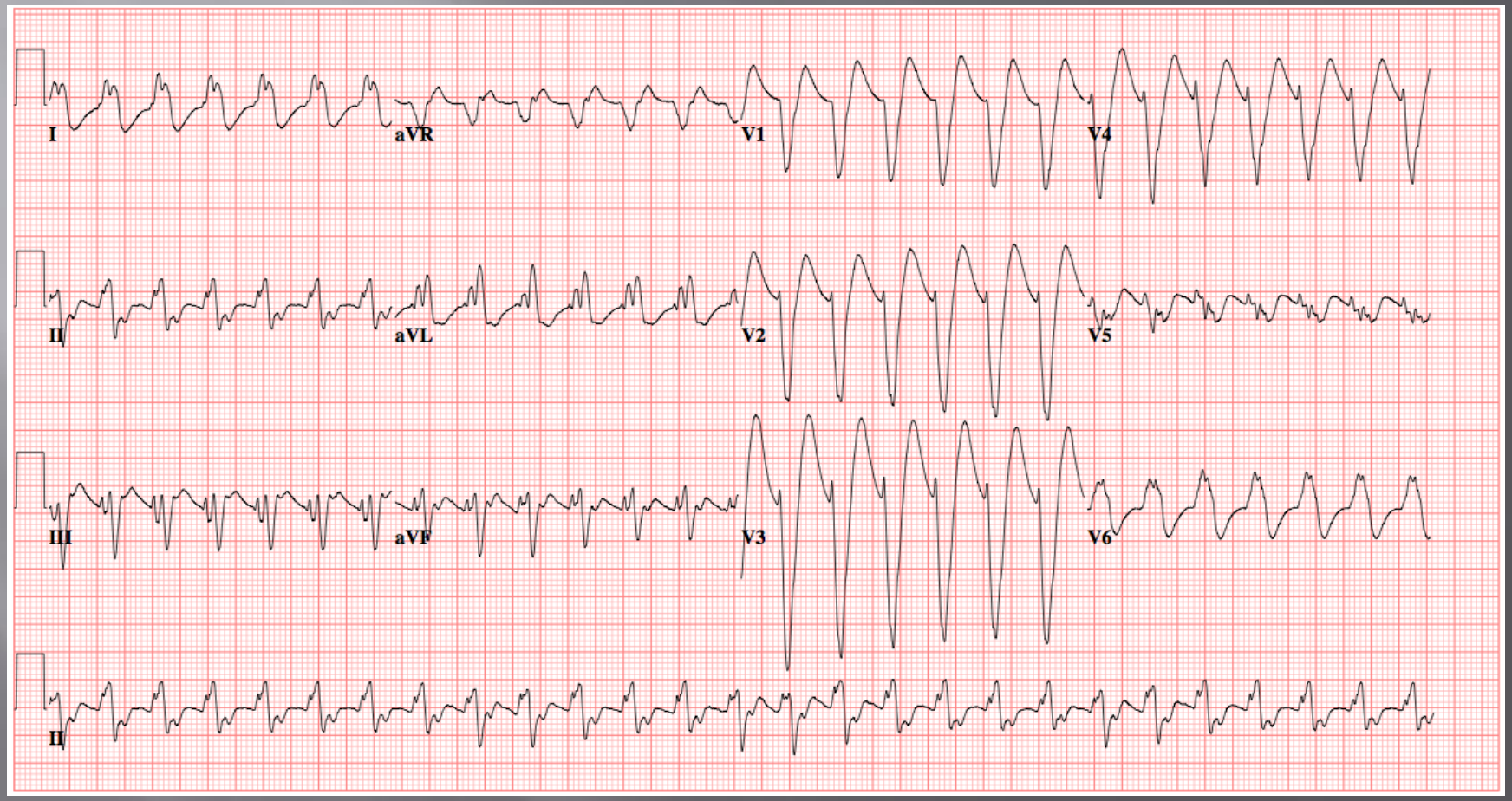
- ECG abnormalities common in poisoned patients (up to 70% in one study*)
- Most findings nonspecific
- Recognition of specific changes can guide therapy

*Homer *et al*. (abstract), Mediterranean Emergency Medicine Congress, 2005

Case

- 20 year old female arrives seizing and unresponsive s/p unknown ingestion
- VS: T 98.9, R 12, P 160 BP 80/45

Electrocardiogram



Sodium Channel Blockade

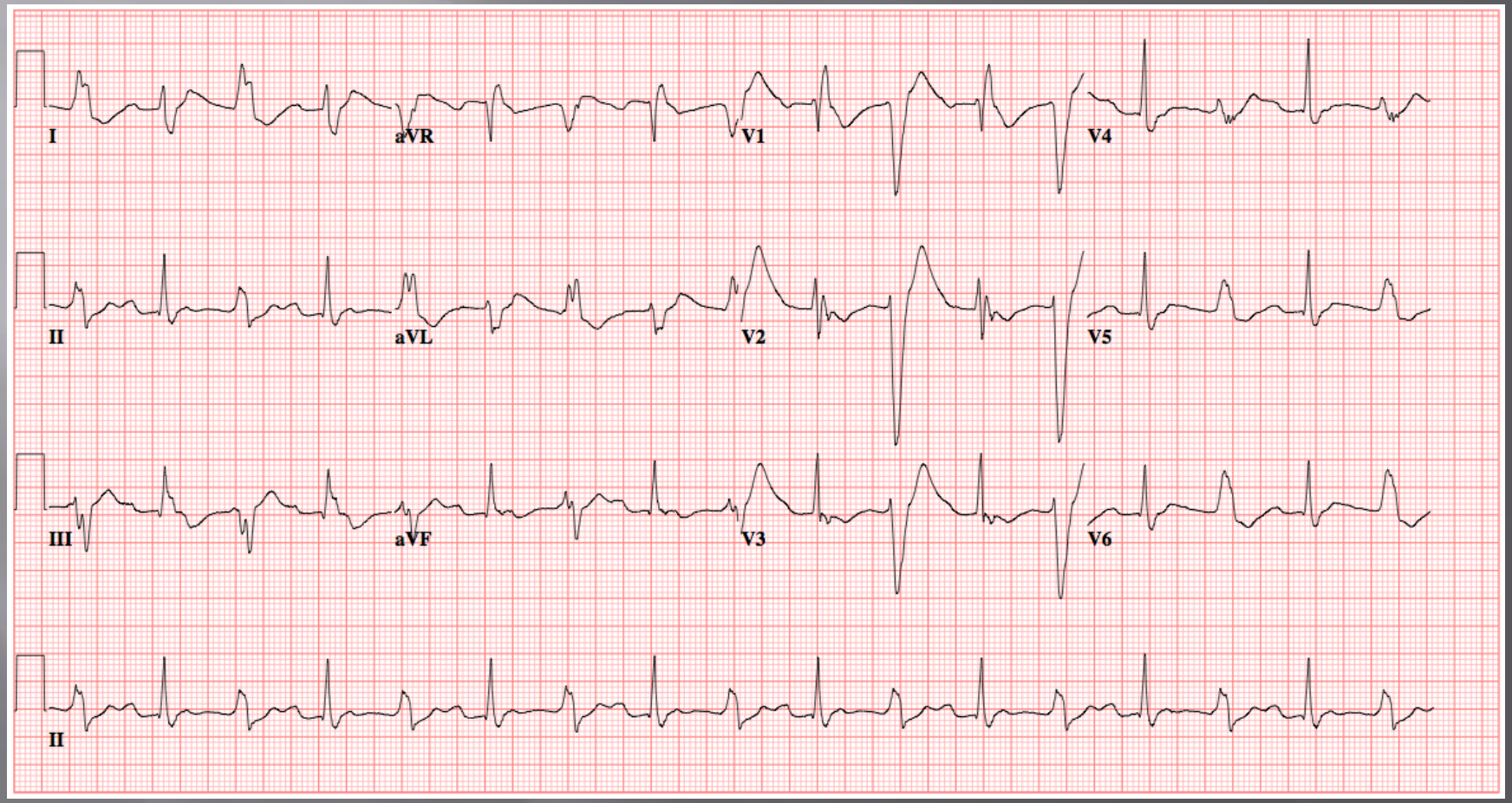
- Wide QRS (>120 ms)
- Tall R wave in aVR

- TCA’s
- Diphenhydramine
- IA/IC antidysrhythmics
- Cocaine
- Propranolol
- The list goes on…

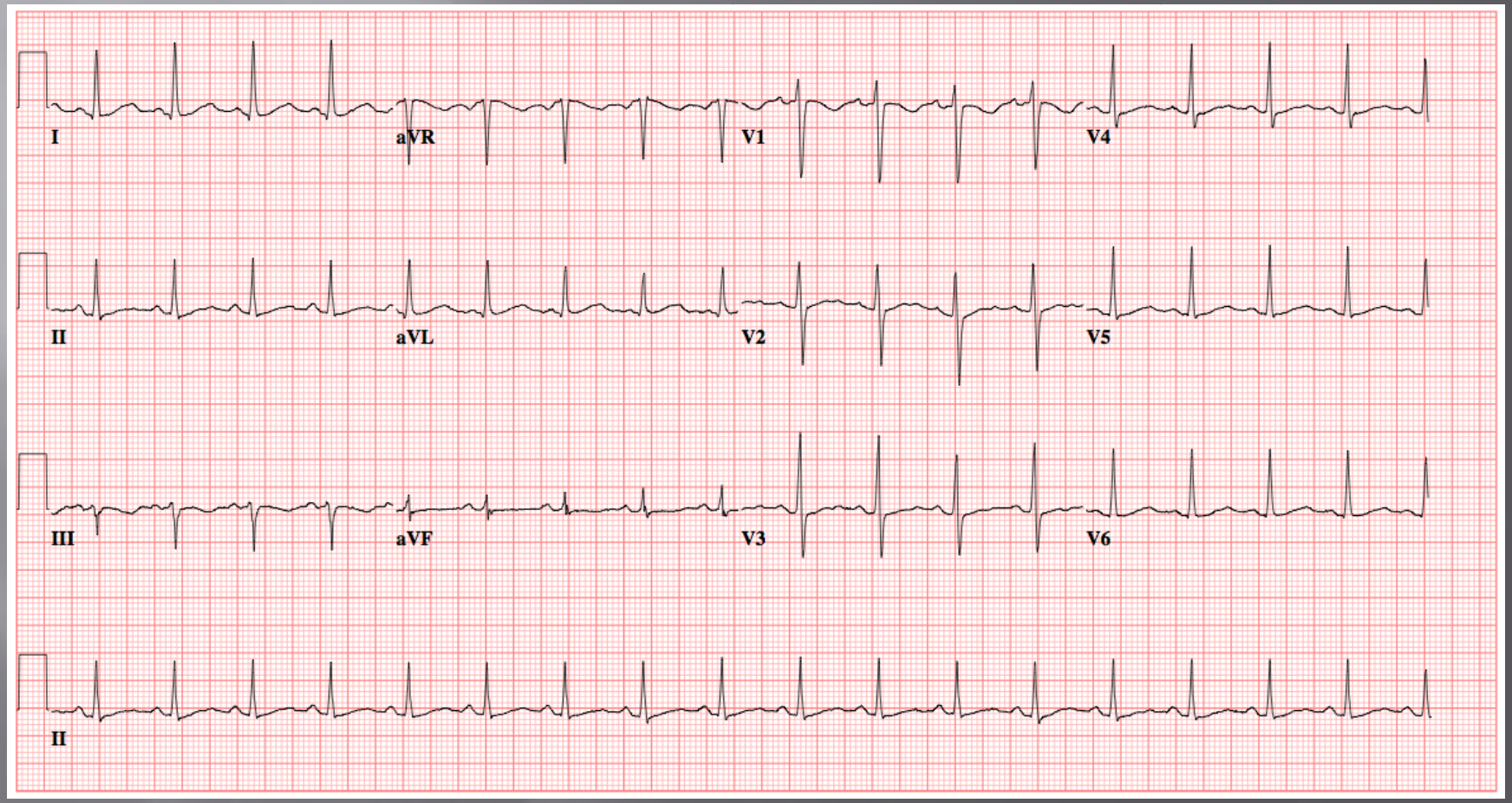
Sodium Channel Blockade

- Treatment
  - Sodium bicarbonate bolus
  - Hyperventilation
  - Hypertonic saline

Electrocardiogram



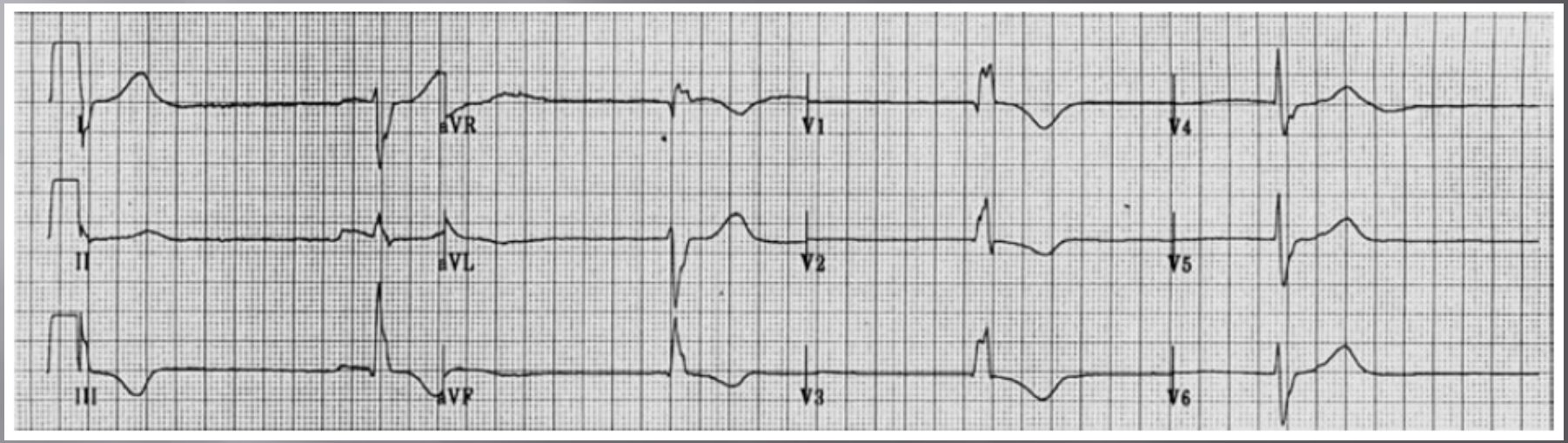
Electrocardiogram



Case

- 68 year old female arrives after unknown overdose
- Drowsy but arousable
- VS: T 98.0, R 12, P 35, BP 60/P

Electrocardiogram



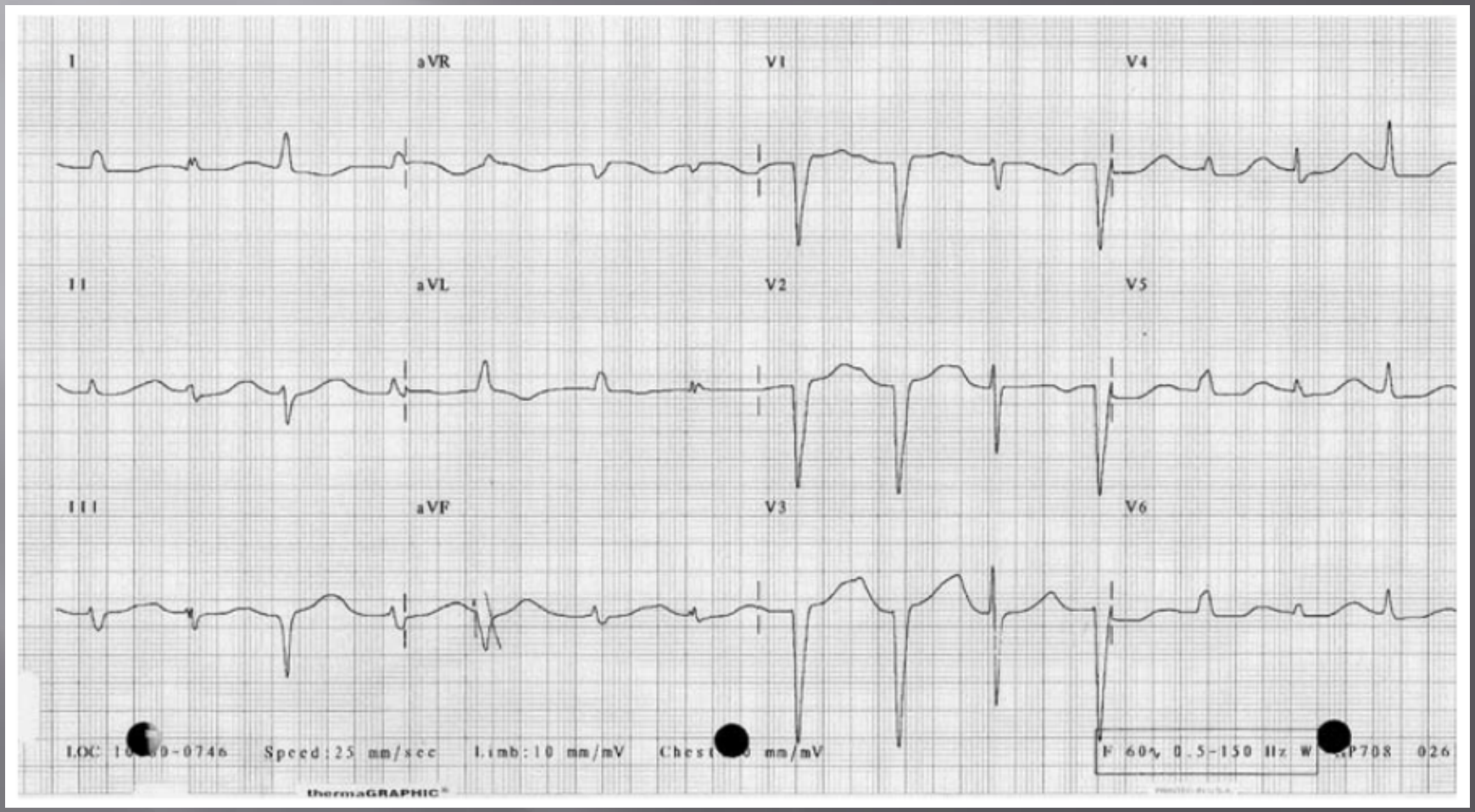
Bradycardia

- Sinus bradycardia
- Junctional rhythm
- Ventricular escape rhythm
- Atrial tachycardia with block

Bradycardia

- Calcium channel blockers
- Beta blockers
- Clonidine & imidazolines
- Digoxin

Electrocardiogram



QTc Prolongation

- Many medications can cause prolonged QTc
- Rarely causes problems
- Be concerned if patient is bradycardic

QTc Prolongation

Laboratory Analysis

Labs

- Not a substitute for a thorough history and physical exam!
- Recommended labs:
  - Metabolic panel (everyone)
  - Acetaminophen level (everyone)
  - Salicylate level (if exam/VS suggestive)
  - Osmol gap (maybe)

Labs

- Specific drugs (as indicated):
  - Ethanol
  - Valproic acid
  - Carbamazepine
  - Phenytoin
  - Lithium
  - Digoxin

The Urine “Tox Screen”

- Commonly ordered
- Rarely helpful
- Does not imply causality, only exposure
- Lots of false positives/negatives
- Don’t rely on it to guide management decisions

Treatment of the Poisoned Patient

Decontamination

- Providers tend to overestimate potential benefits
- Little data showing improvement in outcomes
- Should only be considered after consideration of risks and benefits

Syrup of Ipecac

- Derived from roots of ipecacuanha plant
- Direct chemoreceptor zone action
- May cause prolonged emesis and sedation
- No proven benefit
- Not recommended

Activated Charcoal

- Large surface area
- Adsorbs many ingested xenobiotics
- Shown to reduce AUC for many substances
- No improvement in outcomes

Activated Charcoal

- Doesn't work with
  - Metals
  - Ions
  - Alcohols
- Don't use with
  - Caustics
  - Vomiting patient
  - Depressed mental status

Activated Charcoal

- Complications
  - Emesis
  - Aspiration
  - Bowel perforation/obstruction with MDAC
- May consider if patient presents <1 hour s/p ingestion of worrisome substance

Gastric Lavage

- Large bore tube placed into stomach (NGT if liquid ingestion)
- Gastric cavity irrigated & aspirated to remove material

Gastric Lavage

Gastric Lavage

Gastric Lavage

Gastric Lavage

Gastric Lavage

Gastric Lavage

- Complications
  - Hypoxia
  - Aspiration
  - Laryngospasm
  - Dysrhythmias
  - Perforation
- Not routinely recommended

Whole Bowel Irrigation

- Polyethylene glycol
- Physically “flush” the GI tract of unabsorbed xenobiotics
- Limited data
- Consider in:
  - Iron & other metals
  - Sustained-release medications
  - Enteric coated products
  - Body packers (mules)

Whole Bowel Irrigation

- Contraindications
  - Ileus
  - Bowel obstruction/perforation
  - Hemodynamic instability

Antidotes

- Not necessary in most poisonings
- Can be lifesaving in selected patients
- Consider expected side effects and contraindications before use

N-Acetylcysteine

- Used primarily in acetaminophen poisoning
- Fully protective if given up to 8 hours post-ingestion
- Detoxifies NAPQI (toxic metabolite)
- Can give with charcoal
- Cons: smells bad, can cause vomiting, hypotension/rash (IV)

Naloxone

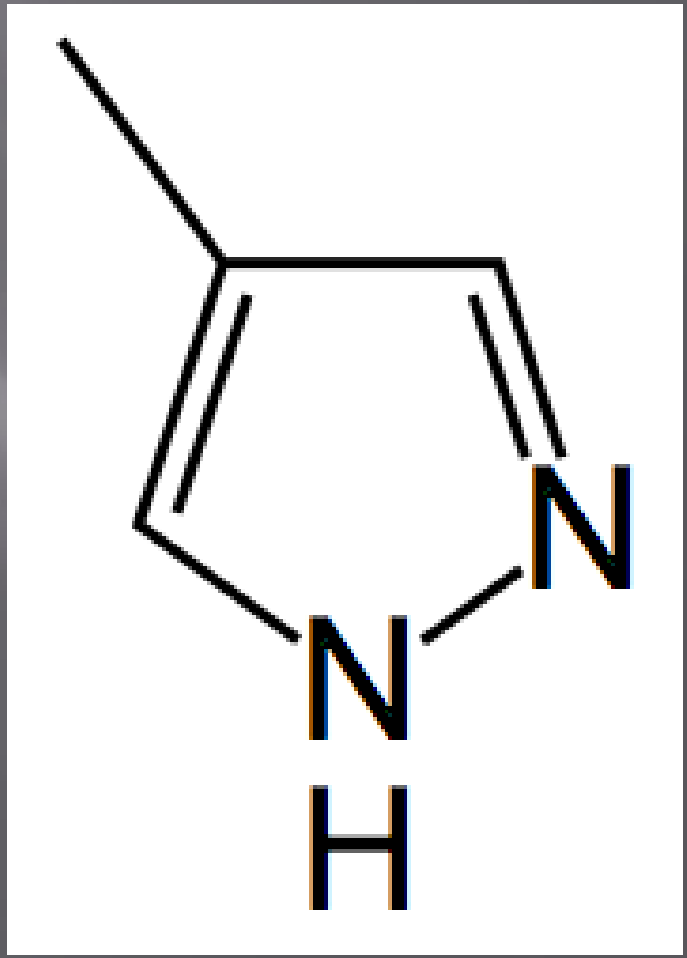
- Opioid poisoning
- IV is preferred route but can give IM/SC
- Goal is reversal of respiratory depression, not awakening patient!
- Can precipitate opioid withdrawal
- Shorter-acting than many opioids

Flumazenil

- Benzodiazepine receptor antagonist
- Useful in carefully selected patients
- May precipitate life-threatening withdrawal in chronic benzo users
- Do not use in patients who may have ingested seizure-inducing medications

Fomepizole

- 4-methylpyrazole
- Potent inhibitor of alcohol dehydrogenase
- Preferred over ethanol for toxic alcohol poisoning
- Does not cause sedation or hypoglycemia



Antibody Fragments (Fab)

- Rattlesnake envenomation
- Black widow envenomation
- Digoxin poisoning

Antibody Fragments (Fab)

- Most sheep-derived
- Expensive
- Anaphylactoid reactions (uncommon)
- Contraindications
  - Allergy to horse or sheep serum
  - Papaya allergy

Hydroxocobalamin

- Vitamin B_{12} precursor
- Binds cyanide irreversibly to form cyanocobalamin
- Turns body fluids red
- Can interfere with lab testing
- Has largely supplanted use of cyanide antidote kit

Methylene Blue

- Used to treat methemoglobinemia
- Cofactor for NADPH-methemoglobin reductase enzyme
- Avoid in G6PD deficiency

Enhancement of Clearance

Alkalinization

- May enhance excretion of weak acids
- “Ion-trapping”
- IV sodium bicarbonate (bolus)
- Consider in poisoning with:
  - Salicylates
  - Phenobarbital
  - Chlorpropamide
  - Methotrexate
- Avoid over-alkalinization

Dialysis

- Useful in xenobiotics with:
  - Small molecular weight (<500 Daltons)
  - Low Vd (usu. <1 L/kg)
  - Low protein binding
- Clears xenobiotic
- Corrects acid-base abnormalities

Dialysis

- Consider in:
  - Salicylates
  - Toxic alcohols
  - Lithium
  - Theophylline
  - Valproic acid (severe poisoning)

Other Methods

- Urinary acidification – not recommended
- Forced diuresis – not recommended
- Charcoal hemoperfusion – not widely available
- Multi-dose activated charcoal
  - Theophylline
  - Phenobarbital
  - Dapsone
  - Carbamazepine
  - Quinine

Shipboard Treatment

- ABC’s are paramount
- Consider charcoal if <1 h and no contraindications
- No ipecac, gastric lavage, or induced emesis!
- Antidotes helpful in select patients (esp. bicarb, NAC)
- If concerned, transfer to MTF ASAP or call Poison Control Center (800-222-1222)

Shipboard Treatment

- Most patients will recover with careful supportive care
- History and physical exam can provide important clues
- Look for toxidromes
- Antidotes helpful in select patients
- Consider decontamination & elimination enhancement

Question #1

- A patient presents to you after having ingested ten 800-mg ibuprofen tablets 4 hours ago. Which of the following treatments is indicated?
  - A. Whole bowel irrigation
  - B. Gastric lavage
  - C. Activated charcoal
  - D. Syrup of ipecac
  - E. None of the above

Question #1

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Question #2

- A patient is brought to the medical department comatose. Vital signs are as follows: T 97.9, P 60, R 4, BP 105/70. Pupils are 1 mm diameter bilaterally. Which of the following treatments would be most helpful?
  - A. N-acetylcysteine
  - B. Activated charcoal
  - C. Naloxone
  - D. Sodium bicarbonate
  - E. Methylene blue

Question #2

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  - E. Methylene blue

Question #3

- A 22-year old male is brought in by shipmates for strange behavior. He is confused, has dry warm skin, pupils are 6 mm bilaterally, and vital signs are as follows: T 100.6, R 12, P 130, BP 126/72. Which of the following did he most likely ingest?
  - A. Jimson weed
  - B. Cocaine
  - C. Methamphetamine
  - D. Heroin
  - E. Alcohol

Question #3

- A 22-year old male is brought in by shipmates for strange behavior. He is confused, has dry warm skin, pupils are 6 mm bilaterally, and vital signs are as follows: T 100.6, R 12, P 130, BP 126/72. Which of the following did he most likely ingest?
  - A. Jimson weed
  - B. Cocaine
  - C. Methamphetamine
  - D. Heroin
  - E. Alcohol

Question #4

- Which of the following interventions should always be performed on a potentially poisoned patient?
  - A. Assess and secure airway as needed
  - B. Obtain intravenous access
  - C. Provide supportive care
  - D. Call Poison Control Center
  - E. All of the above

Question #4

- Which of the following interventions should always be performed on a potentially poisoned patient?
  - A. Assess and secure airway as needed
  - B. Obtain intravenous access
  - C. Provide supportive care
  - D. Call Poison Control Center
  - E. All of the above

Questions?

Acute Allergic Reactions and Anaphylaxis

LCDR NATE CLAPP MD, MS

FAMILY MEDICINE/FLIGHT SURGERY

FLEET SURGICAL TEAM THREE

Disclosure

- I have no financial or other interests involving any products or companies that will be discussed in this lecture

Objectives

- Define allergic reactions and anaphylaxis
- Understand the mechanisms through which these reactions occur
- Treat acute allergic reactions and anaphylaxis
- Manage patients appropriately after an allergic or anaphylactic reaction

Anaphylaxis: How Common Is It?

- Approximately 1,500 deaths per year in US
- Number of non-fatal reactions is not known
  - presumed to be around 100,000
  - 66% are new cases
  - Parenteral and topical agents>oral
- Condition poorly defined until 2004

- 2005 definition agreed upon by:
- National Institute of Allergy and Infectious Disease (NIAID)
- Food Allergy and Anaphylaxis Network symposium

Definitions

- Allergy – acquired potential to develop immunologically-mediated adverse reactions to normally innocuous substances

- Anaphylaxis
  - “A serious allergic reaction that is rapid in onset and may cause death”.
  - Has clinical criteria

Anaphylaxis Criteria

- Acute onset of illness (minutes to hours) with involvement of skin, mucosa or both, and at least one of the following:
  - Respiratory compromise
  - Reduced blood pressure (SBP <90) or symptoms of end-organ dysfunction
- Or Two or more of the following:
  - Skin-mucosal involvement
  - Respiratory compromise (
  - Reduced blood pressure/end-organ compromise
  - Persistent GI symptoms (Nausea, vomiting,
- Or
  - Reduced BP after exposure to known allergen (PCN, peanuts, etc…)

Same Thing/Different Look

TABLE I. Clinical criteria for diagnosing anaphylaxis

Anaphylaxis is highly likely when any one of the following 3 criteria are fulfilled:

1. Acute onset of an illness (minutes to several hours) with involvement of the skin, mucosal tissue, or both (eg, generalized hives, pruritus or flushing, swollen lips-tongue-uvula)
   AND AT LEAST ONE OF THE FOLLOWING
   a. Respiratory compromise (eg, dyspnea, wheeze-bronchospasm, stridor, reduced PEF, hypoxemia)
   b. Reduced BP or associated symptoms of end-organ dysfunction (eg, hypotonia [collapse], syncope, incontinence)
2. Two or more of the following that occur rapidly after exposure *to a likely allergen for that patient* (minutes to several hours):
   a. Involvement of the skin-mucosal tissue (eg, generalized hives, itch-flush, swollen lips-tongue-uvula)
   b. Respiratory compromise (eg, dyspnea, wheeze-bronchospasm, stridor, reduced PEF, hypoxemia)
   c. Reduced BP or associated symptoms (eg, hypotonia [collapse], syncope, incontinence)
   d. Persistent gastrointestinal symptoms (eg, crampy abdominal pain, vomiting)
3. Reduced BP after exposure to *known allergen for that patient* (minutes to several hours):
   a. Infants and children: low systolic BP (age specific) or greater than 30% decrease in systolic BP*
   b. Adults: systolic BP of less than 90 mm Hg or greater than 30% decrease from that person's baseline

Allergy Terms

- Urticaria (hives)
  - Blood vessel dilation and edema of the dermis
  - Cutaneous elevations (wheals)
  - Pruritic
  - Superficial
  - Polymorphic
- Angioedema
- Anaphylaxis

A Picture Is Worth 1000 Words

Angioedema

Urticaria

Pruritis

Pathophysiology of Allergic Reactions

- Type I (Immediate hypersensitivy): IgE driven
- Two step process
- Step 1: Sensitization (First time immune system decides the antigen is not its friend)
- Step 2: Re-exposure to antigen>>activation of mast cells and basophils>>degranulation and release of mediators

Mediators of Anaphylaxis

- Histamine (most important)
  - Increased vascular permeability (H1 and H2). Vasodilation, shock, angioedema, urticarial
  - Smooth muscle contraction (H1)
    - Brochoconstriction, GI effects (vomiting/diarrhea), uterine contraction
  - Cardiac
    - Coronary artery spasm (H1)
    - Increased heart rate (H2)
  - Increased glandular secretion (H1 and H2) (mucus/saliva)
  - GI: Increased gastric acid secretion (H2)
- Leukotrienes and prostaglandins
- Cytokines

Target Organs

Cardiovascular	Hypotension (30%), syncope, arrhythmia, angina
Respiratory (50% of cases)	Upper – pharyngeal or laryngeal edema Lower – bronchospasm
GI (30% of cases)	Nausea, vomiting, diarrhea, cramping
Skin (88% of cases)	Flushing, erythema, pruritus, urticarial, angioedema
Central nervous system	Headache, confusion, altered mental status

Clinical Spectrum and Time Course

Clinical Manifestations

- Nasal congestion
- Urticaria
- Angioedema
- Presyncope/bronchospasm
- Cardiovascular collapse and respiratory failure

- **Skin involvement occurs in 88% of all reactions
- **Must look out for the other 12%

Time Course of Presentation

- Immediate/early onset
  - 5-30 min after parenteral
  - 2 hours after oral
  - Most fatalities occur within 30 min
- Biphasic anaphylaxis
  - Second wave reaction
  - Occurs in 1-20% of cases of anaphylaxis
  - 1-72 hours later, most within 8 hours
  - Severity of initial reaction not predictive

Etiologic Agents

Anaphylactic (IgE-mediated)

- Food
- Medications
- Insect Venom
- Latex
- Exercise

Anaphylactoid: NOT IgE-mediated

- Opioids
- Aspirin and NSAIDS
- Radiocontrast media

- Mimics anaphylaxis (treatment is the same)
- Immediate systemic reaction
- May occur on first exposure
- Level of reaction depends on degree of exposure

Treatment of Allergic Reaction

- IV
- Oxygen
- Monitor
- Benedryl (diphenhydramine) 50 mg IV (H1 blocker)
- Zantac (ranitidine)50 mg IV
- Albuterol (wheezing/SOB)
- Steroids (take 4-6 hours to take effect)
  - Decadron 10 mg IV
  - Solumedrol 125 mg IV

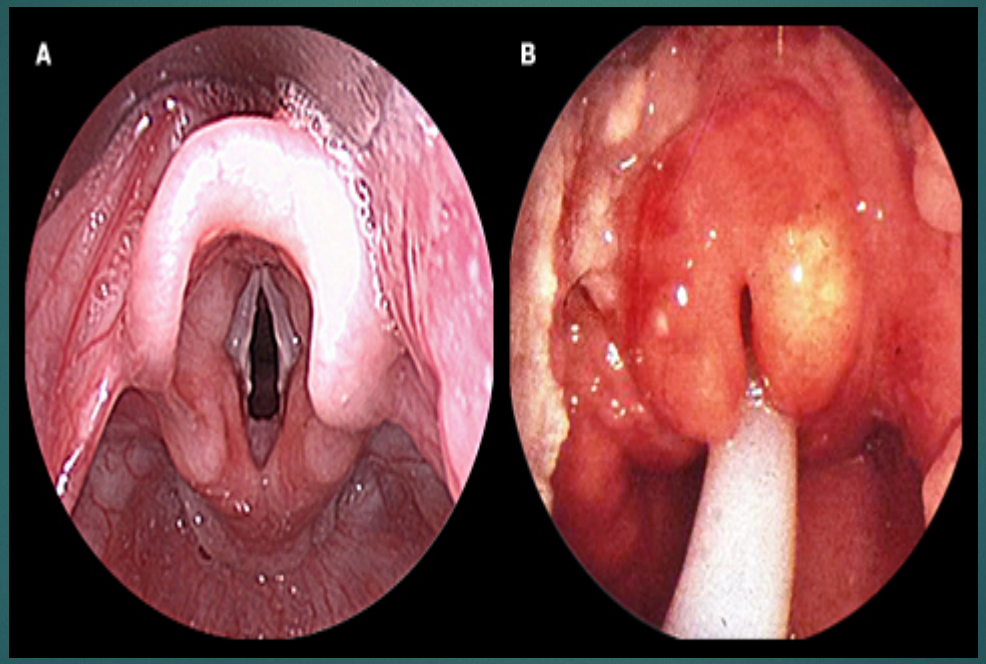
H2 Blockers are important

	Diphenhydramine 50 mg IV + ranitidine 50 mg IV	Diphenhydramine 50 mg IV + Placebo
Urticaria at 2 hours	8%	26%
Need for additional Anti-histamines	4%	23%

Treatment of Anaphylaxis

- IV
- Oxygen and Prepare for difficult airway (Bougie or glidescope)
- Monitor
- Epinphrine 1:1000 0.3-0.5 mL SC or IM q5 min OR
- Epinephrine drip (1 mg in 1 L NS. Start 1 cc/min titrate every minute) OR
- Epinephrine 1:10,000 1-5 cc IV (0.1 mg/ml)
- “Epinephrine is the drug of choice for anaphylaxis” (World Allergy Organization)
  - Bronchodilator, chronotrope and inotrope
- Glucagon 1-5 mg IV if patient on Beta Blocker

Airway Management



Management

- Monitor for 8 hours (cover the second wave)
- Admit if:
  - Severe presenting symptoms even if resolved
  - History of severe, protracted or recurrent anaphylaxis
  - Comorbidities (asthma, CHF, Renal disease)
  - Concurrent beta blocker use

Medications at Discharge

- Epipen (0.3 mg) IM and teach how to use it
- H1 blocker (3-7 days)
- H2 blocker (3-7 days)
- Corticosteroids (3-7 days)

Question 1

- Allergic reactions commonly involve the skin and mucosa. What percentage of cases do not involve skin or mucosa?
  - A. 1%
  - B. 6%
  - C. 12%
  - D. 21%

Question 2

- Which of the following statement(s) meet the definition of anaphylaxis?
  - A. Acute onset of illness (minutes to hours) with involvement of skin or mucosa AND respiratory compromise
  - B. Reduced blood pressure after exposure to a known allergen
  - C. Skin or mucosal involvement AND persistent GI symptoms
  - D. All of the above
  - E. A and B only
  - F. A and C only

Question 3

- You are underway and a 50-year old Master Chief weighing 70 kg presents to Medical complaining of throat swelling, difficulty breathing and pruritic hives. Which of the following is an inappropriate dose/route of epinephrine administration combination to treat his anaphylactic reaction?
  - A. Epinephrine 1:1000 1-5 mL IV
  - B. EpiPen 0.3 mg IM
  - C. Epinephrine 1:1000 0.2-0.5 mL IM
  - D. Epinephrine 1:1000 0.2-0.5 mL SC

Question 4

- You find out the Master Chief is on Toprol (metoprolol) XL 50 mg daily for hypertension. Which of the following aduncts is MOST LIKELY to improve his treatment?
  - A. Diphenhydramine (Benadryl) 50 mg IV
  - B. Ranitidine (Zantac) 50 mg IV
  - C. Glucagon 5 mg IV
  - D. Solumedrol 125 mg IV

Pearls and Pitfalls

- Give epinephrine to everyone with respiratory or cardiovascular symptoms (Don’t wait for them to get bad)
- Remember to give an H2 blocker in addition to the H1 blocker
- Low threshold for admission/observation
- Most second wave phases occur within 8 hours
- Don’t forget Glucagon if patient on a beta blocker
- Know your epinephrine doses/routes of administration.
  - Make it simple and teach your Corpsmen

Questions

Fleet Dental

Sara A. Chilcutt LT DC USN
Fleet Division Officer/ Fleet Liaison Officer
NBHC Naval Base San Diego
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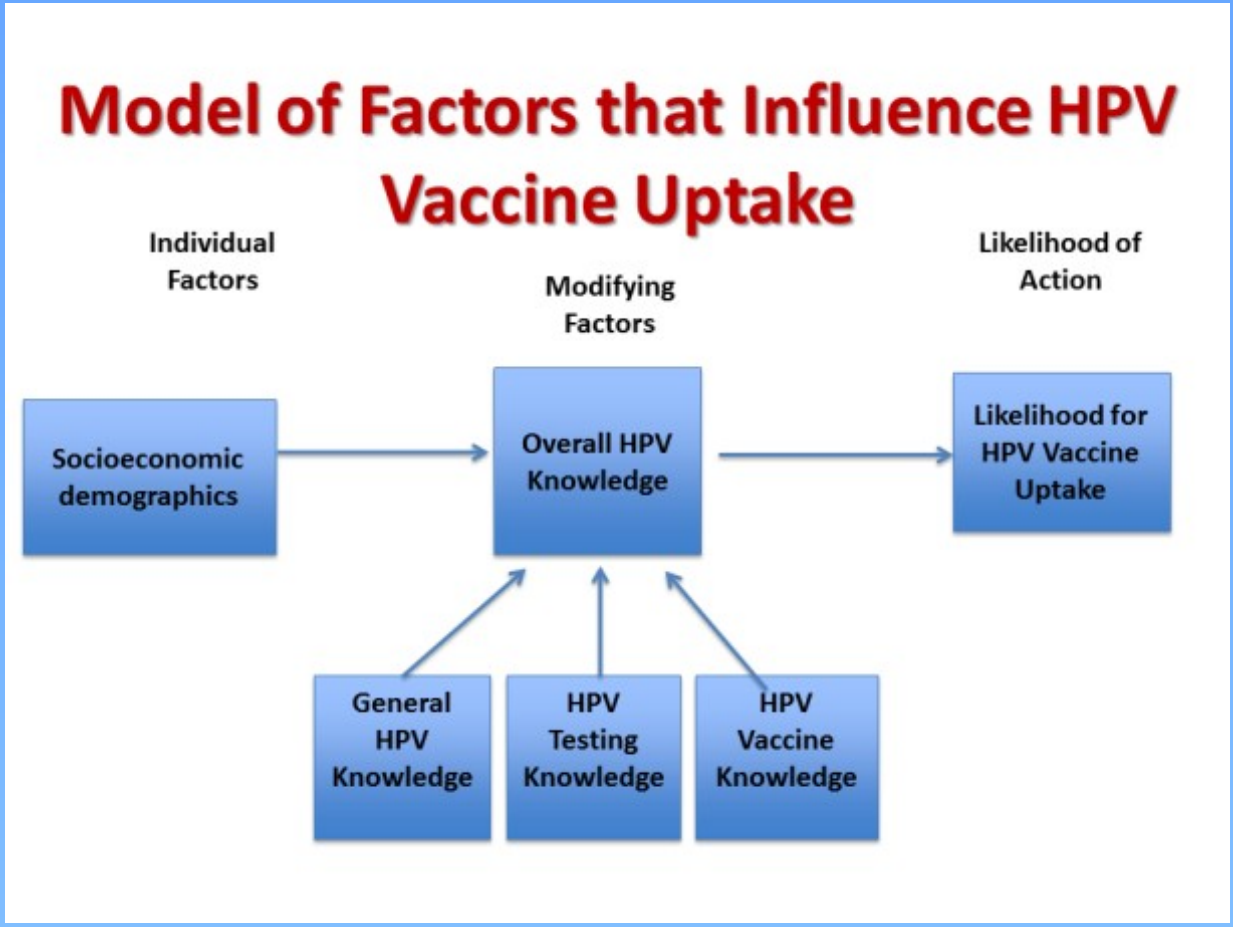
HPV Knowledge and HPV Vaccine Uptake Among U.S. Navy Personnel 18 to 26 Years of Age

Jennifer Buechel, CDR, NC, USN

Introduction

- PhD Candidate at the University of San Diego, California
- Obtained NMCSD and USD IRB approvals
- Federally funded grant under the Tri-Service Nursing Research Program
- Obtained research setting approval from the Commander, U.S. Navy Forces Pacific
- All COs and XOs (SURFPAC) are aware
- Study recruitment phase began late May 2015

Study Purpose



Study Methods

- Inclusion Criteria:
  - Active duty (or reserve on active status) in the U.S. Navy between 18 and 26 years old
  - *Goal of 250 participants*
- Electronic survey using Max Survey software
- Recruitment Strategies:
  - First: Batch emails
  - Second: Advertisements
  - Third: In person

Study Update

- Only 30 eligible participants have completed the survey
- If you have not sent out the batch emails, please do so
- Create ways for recruiting:
  - Safety Stand Downs, Health and Wellness Fairs
  - PHAs/Well Woman Exams
  - Learning tools for junior medical personnel
  - PODs, ship papers

Special Thanks

- All the Medical Readiness Division (MRD) personnel
- Site visits with DDG-73, DDG-110, LSD-49
- USS Makin Island's medical department personnel are the bomb!! Big thanks!!
- Individual providers
- *Welcome suggestions and ideas, research among the fleet is a team effort!*
- *If you are within the age range, please come see me to complete the survey (medical personnel not exempt)*

Contact Information

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Primary #: 734-250-4190
Secondary #: 619-825-7385

Medical Readiness Division

MRD_SD_GMO@navy.mil
(619) 556-5191
Bldg 116
San Diego, CA 92136

Active Duty Clinic-Gen Surgery

- Director, MRD CDR Hoang has volunteered to see common general surgery pathology on Fridays at Dept of Surgery, NMCSD to fast track fleet referrals, including:
  - Soft tissue (lipoma, epidermal inclusion cyst, pilonidal cyst);
  - Anal disease (hemorrhoid, anal/rectal abscess);
  - Screening colonoscopy
  - Symptomatic cholelithiasis
  - Hernia (ventral, incisional, inguinal, umbilical)

  - Gen surg matrix referral rules still apply.

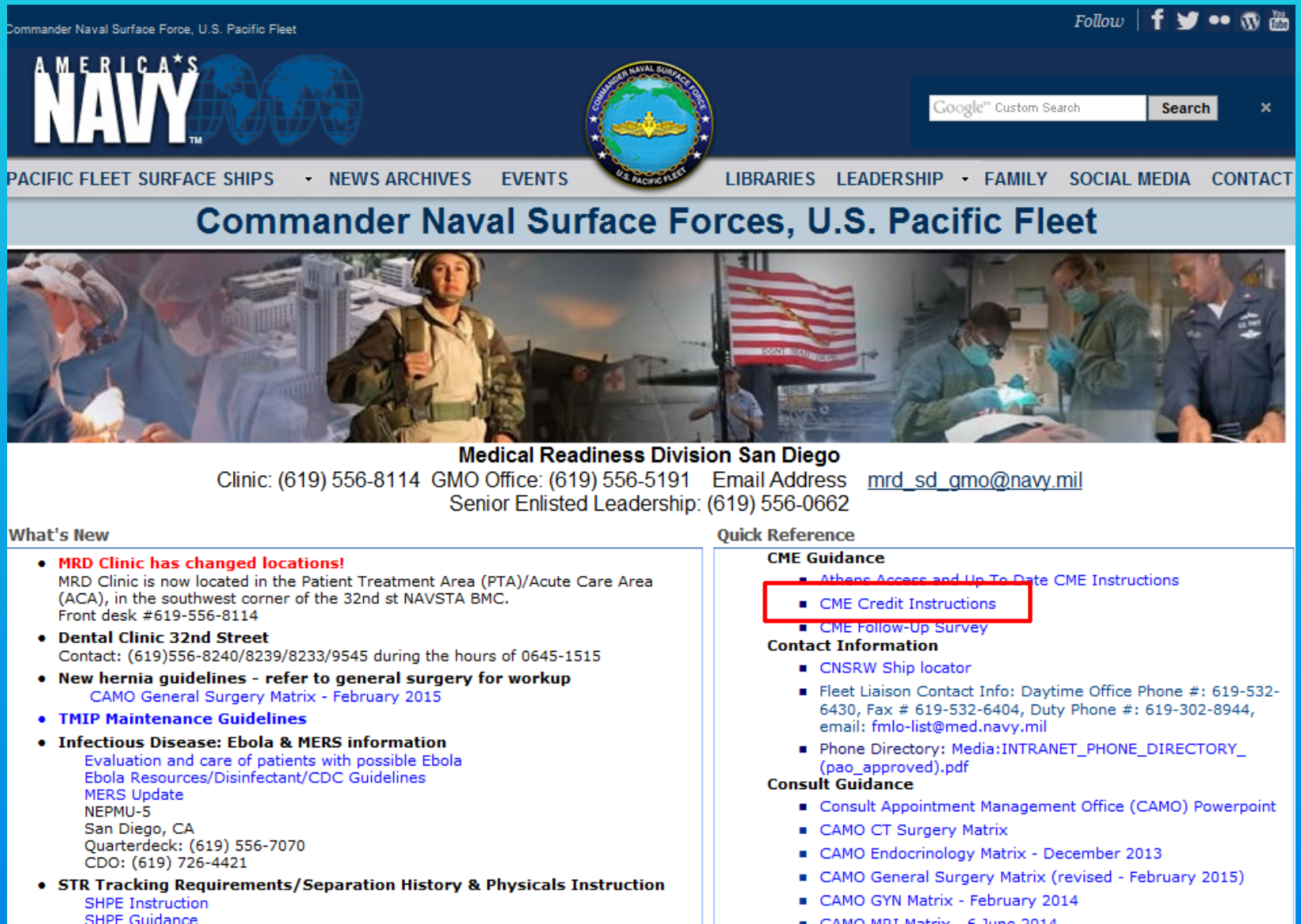
- Conditions requiring long term follow up will not be included in active duty clinic, unless discussed with MRD Physician Supervisors.

- Include “forward to Dr. Hoang” in body of the referral.

Upcoming Meetings

- July 29th @ 1000-1200
  - Trauma
  - Psych Emergencies
- August 27th @1000-1200
  - X-ray interpretation (GMOs)
  - Pelvic/speculum exam (IDCs)
- September 30th @1000-1200
  - Ortho emergencies + Splint/Cast basics
  - Prev Med
- October 28th @1000-1200
  - EKG Interpretation
  - Optho Emergencies
  - ACR

CME – how to


Commander Naval Surface Force, U.S. Pacific Fleet
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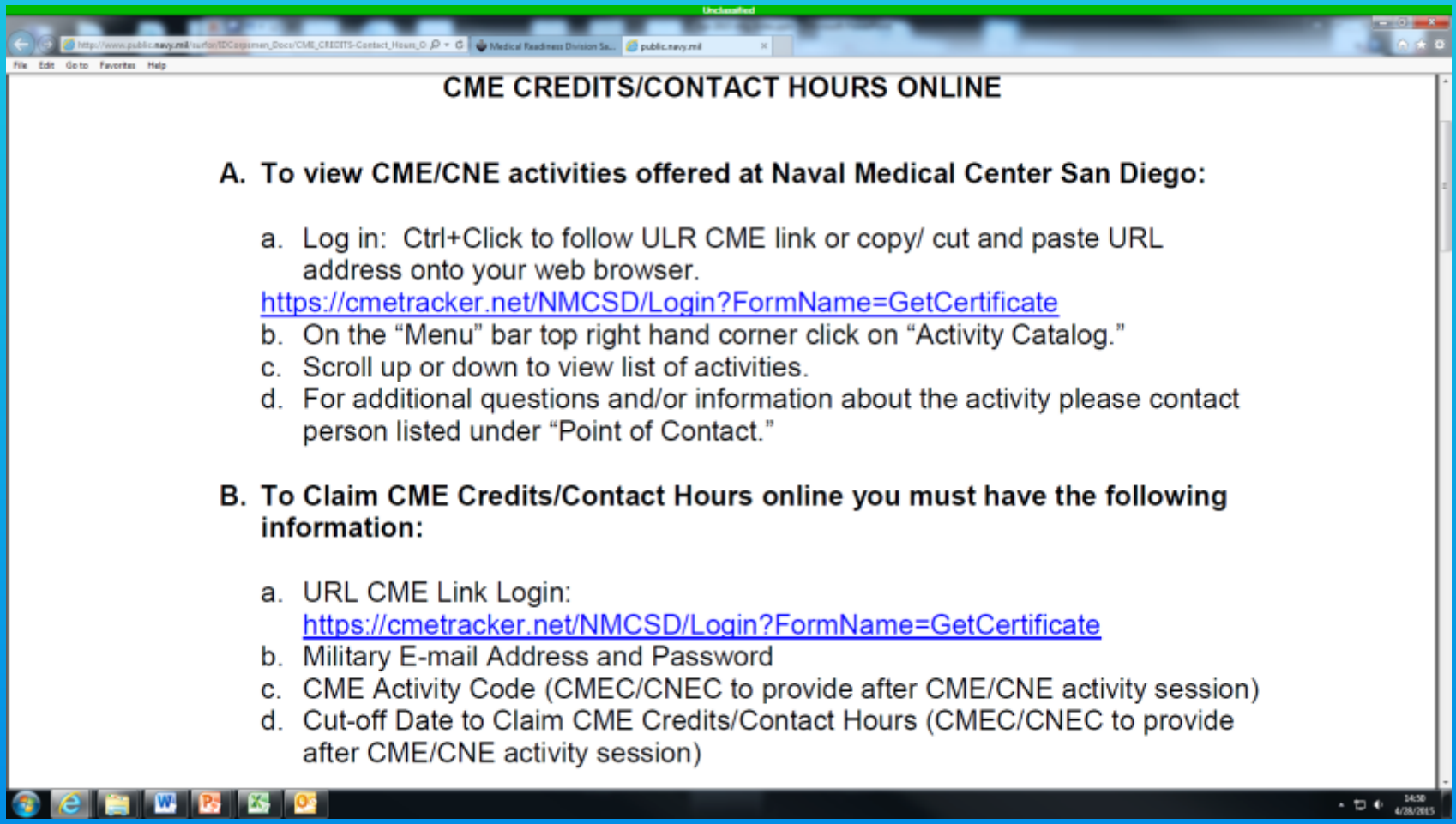
SOCIAL MEDIA
CONTACT
Commander Naval Surface Forces, U.S. Pacific Fleet
Medical Readiness Division San Diego
Clinic: (619) 556-8114 GMO Office: (619) 556-5191 Email Address mrd_sd_gmo@navy.mil
Senior Enlisted Leadership: (619) 556-0662
What's New
MRD Clinic has changed locations!
MRD Clinic is now located in the Patient Treatment Area (PTA)/Acute Care Area (ACA), in the southwest corner of the 32nd st NAVSTA BMC.
Front desk #619-556-8114
Dental Clinic 32nd Street
Contact: (619)556-8240/8239/8233/9545 during the hours of 0645-1515
New hernia guidelines - refer to general surgery for workup
CAMO General Surgery Matrix - February 2015
TMIP Maintenance Guidelines
Infectious Disease: Ebola & MERS information
Evaluation and care of patients with possible Ebola
Ebola Resources/Disinfectant/CDC Guidelines
MERS Update
NEPMU-5
San Diego, CA
Quarterdeck: (619) 556-7070
CDO: (619) 726-4421
STR Tracking Requirements/Separation History & Physicals Instruction
SHPE Instruction
SHPE Guidance
Quick Reference
CME Guidance
Athens Access and Up To Date CME Instructions
CME Credit Instructions
CME Follow-Up Survey
Contact Information
CNSRW Ship locator
Fleet Liaison Contact Info: Daytime Office Phone #: 619-532-6430, Fax # 619-532-6404, Duty Phone #: 619-302-8944, email: fmlo-list@med.navy.mil
Phone Directory: Media:INTRANET_PHONE_DIRECTORY_(pao_approved).pdf
Consult Guidance
Consult Appointment Management Office (CAMO) Powerpoint
CAMO CT Surgery Matrix
CAMO Endocrinology Matrix - December 2013
CAMO General Surgery Matrix (revised - February 2015)
CAMO GYN Matrix - February 2014

CME – how to



CME CREDITS/CONTACT HOURS ONLINE

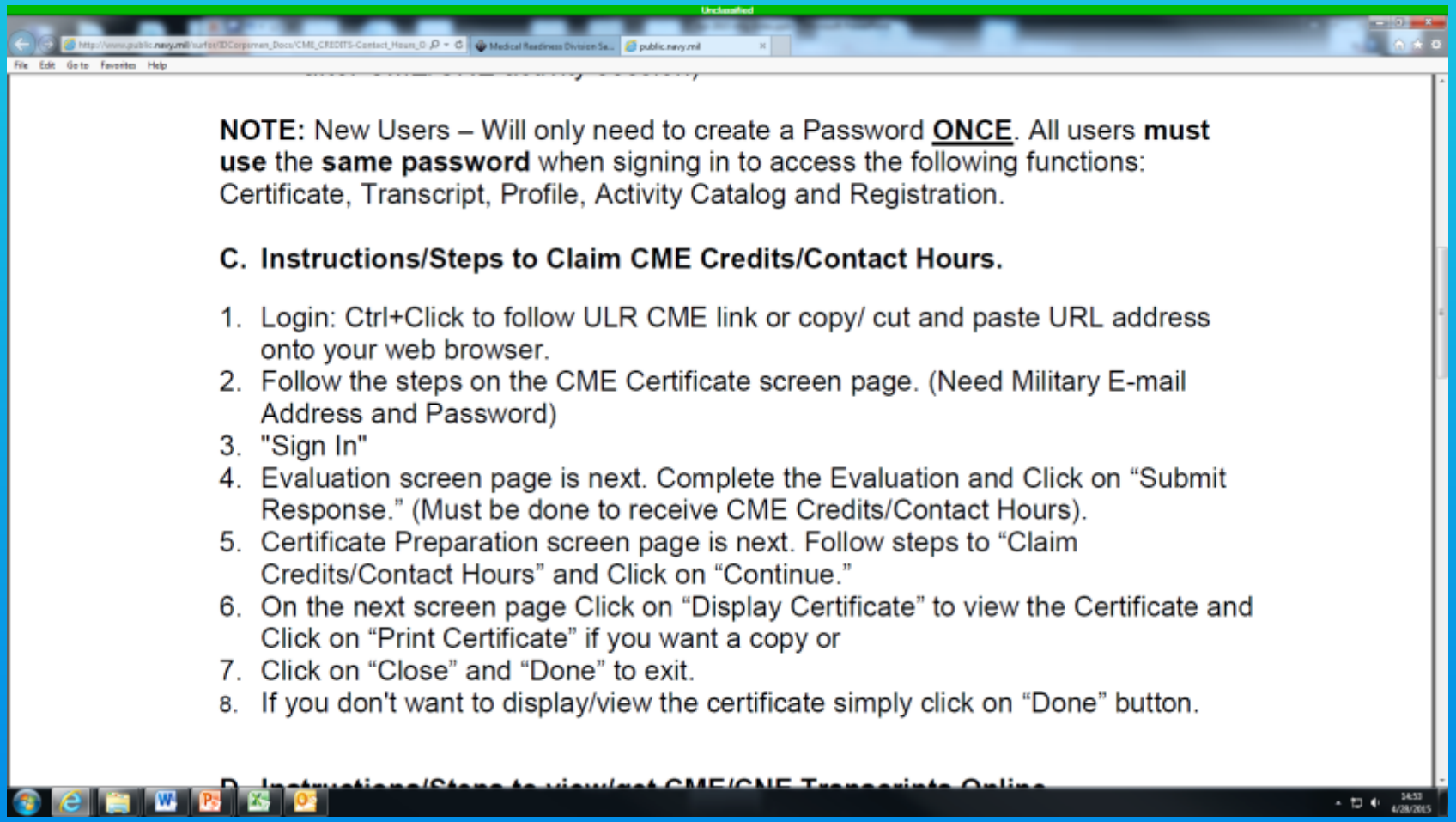
A. To view CME/CNE activities offered at Naval Medical Center San Diego:

a. Log in: Ctrl+Click to follow ULR CME link or copy/ cut and paste URL address onto your web browser.
https://cmetracker.net/NMCSD/Login?FormName=GetCertificate
b. On the "Menu" bar top right hand corner click on "Activity Catalog."
c. Scroll up or down to view list of activities.
d. For additional questions and/or information about the activity please contact person listed under "Point of Contact."

B. To Claim CME Credits/Contact Hours online you must have the following information:

a. URL CME Link Login:
https://cmetracker.net/NMCSD/Login?FormName=GetCertificate
b. Military E-mail Address and Password
c. CME Activity Code (CMEC/CNEC to provide after CME/CNE activity session)
d. Cut-off Date to Claim CME Credits/Contact Hours (CMEC/CNEC to provide after CME/CNE activity session)

CME – how to



NOTE: New Users – Will only need to create a Password **ONCE**. All users **must use** the **same password** when signing in to access the following functions: Certificate, Transcript, Profile, Activity Catalog and Registration.

C. Instructions/Steps to Claim CME Credits/Contact Hours.

1. Login: Ctrl+Click to follow ULR CME link or copy/ cut and paste URL address onto your web browser.
2. Follow the steps on the CME Certificate screen page. (Need Military E-mail Address and Password)
3. "Sign In"
4. Evaluation screen page is next. Complete the Evaluation and Click on “Submit Response.” (Must be done to receive CME Credits/Contact Hours).
5. Certificate Preparation screen page is next. Follow steps to “Claim Credits/Contact Hours” and Click on “Continue.”
6. On the next screen page Click on “Display Certificate” to view the Certificate and Click on “Print Certificate” if you want a copy or
7. Click on “Close” and “Done” to exit.
8. If you don't want to display/view the certificate simply click on “Done” button.

CME – how to

NAVAL MEDICAL CENTER
SAN DIEGO
THE PRIDE OF NAVY MEDICINE
My Profile
My Certificate
My Transcript
My Registrations
Activity Catalog
CME Certificate
Sign In
Welcome!
To evaluate the program and display your certificate, please follow the steps below:
1. Enter your Military Email Address: joseph.lagrew@navy.mil
2. Please select one of the following:
I already have a password, and my password is:
Forgot Password?
I am a new user (You'll create a password later)
3. Enter CME Activity Code 7755
4.
Sign In
(be sure your browser allows pop-ups)
If you would like to view or print a past certificate, please click here
*Note-Reprint of certificates valid only for certificates received after 10-1-11

Post Tests

Please put your name on the quiz!

CME Information

- CME Code (To claim credit online): **7888**
- Closing Date (To claim credit online): **07 JUN 2015**
- To complete CME
  - Log onto the MRD IDC website and click on the CME credit link

    or

  - Go to NMCSD SEAT SharePoint site (via citrix or NMCSD/BMC computer) and click on MRDSD Waterfront Meeting

http://nmcsd-as-spfe05/sites/dpe/setd/Lists/cmesurvey/Item/newifs.aspx?List=be0f840e%2D0489%2D4b5a%2Db8de%2D9c4cd1a323e5&Web=0901130e%2Dd444%45b8%2D8bc7%2D5b9ec10dca77